Health Innovation Wessex

Case study

A primary care network approach to cardiovascular disease (CVD) prevention in areas of health inequality

> **"Today's work today."**
>
> Katie Gutteridge, Practice Manager Bitterne Surgery and Manager Bitterne Primary Care Network has a passion to work with others to promote CVD prevention that includes populations often under-served. Katie believes in making every contact count.

Programme overview

Health Innovation Wessex (HIW) developed a programme with Hampshire and Isle of Wight Integrated Care Board to adopt innovative approaches to address the health inequalities that exist in the prevention and treatment of cardiovascular disease (CVD).

This case study showcases the approach followed within Bitterne Primary Care Network (PCN) and the impact it has had to date.

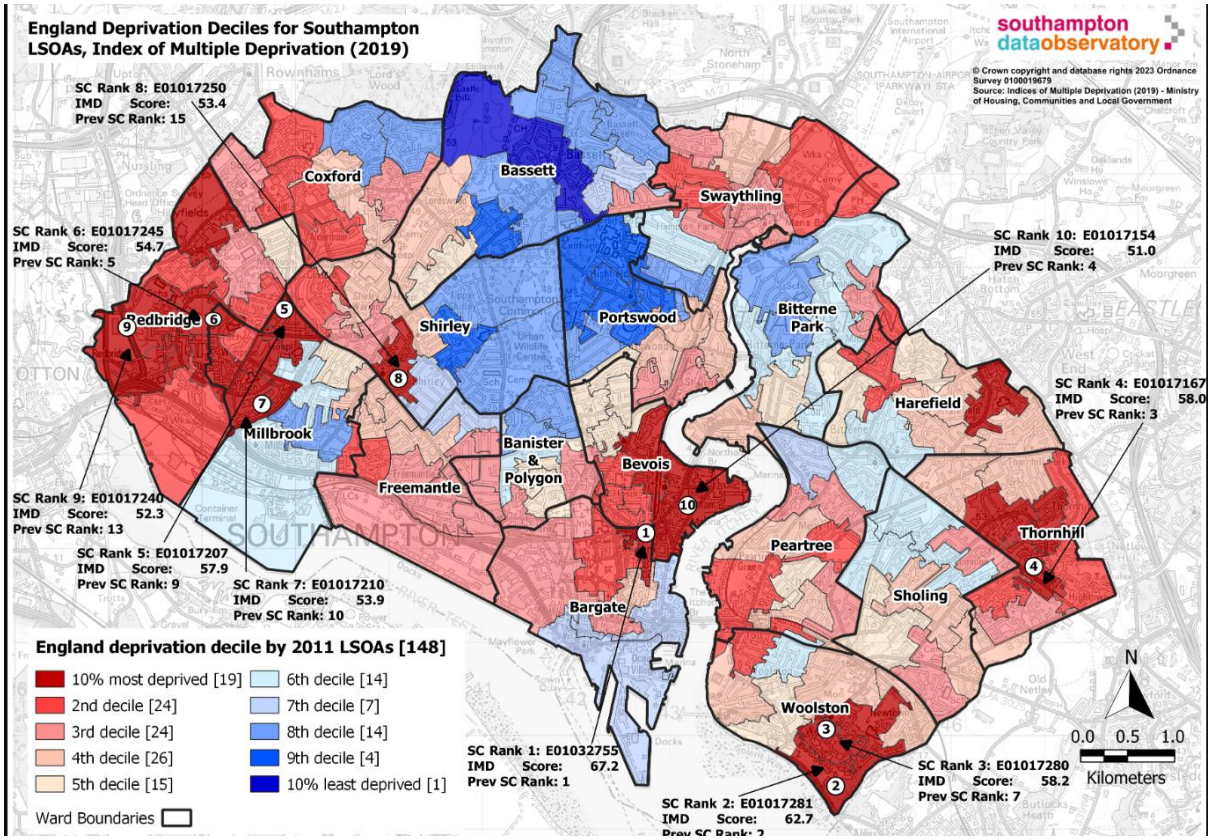
The issue

The Core20PLUS populations in England suffer from poorer health outcomes, accentuated by inequitable access to health and care services and treatment pathways.

CVD prevention within the NHS utilises innovative medicines and medical technologies to improve the quality of healthcare for people, yet access to these can be difficult for people in Core20PLUS populations, often due to work commitments, transportation issues or a reluctance to engage with healthcare services in traditional environments.

Bitterne Surgery serves a population of 17,000 in eastern Southampton, Hampshire. The practice is located in two Southampton suburbs; one located on West End Road in the suburb of Bitterne and the other in Thornhill. Greater health inequalities exist in the Thornhill suburb, while Bitterne serves an older population with more people aged over 75.

Data from the Southampton data observatory shows that Thornhill is an area that falls within the top 10% most deprived deciles on the Index of Multiple Deprivation (2019), and that the practice located on West end road and bordered by Harefield falls within the 2nd most deprived decile regions, as illustrated below in ***infographic 1***.



Infographic 1: *England Deprivation Deciles for Southampton LSOAs, Index of Multiple Deprivation (2019)from the Southampton data observatory*

What we did

The Innovation for Healthcare Inequalities Programme (InHIP) is an NHS England initiative which aims to address the local healthcare inequalities experienced by under-represented groups.

Bitterne PCN was awarded £14,000 to establish community sessions (from May to August 2024) to measure blood pressure and prevent cardiovascular disease in local groups often under-served by health services.

Case finding

To identify the appropriate groups, a review of the excluded patient database was conducted to pick up people who were either hard to get hold of or were due a blood pressure (BP) check.

BP check invites were then sent through text messages using the Accurx software platform.

Promotion of the BP check clinic initiative

The practice Patient Participation Group (consisting of 35 individuals) helped to develop the messaging for the initiative. Promotional posters were put up in surgery waiting rooms, on the surgery TV loop system and uploaded to the practice website. Posters were also displayed in a local church, where Saturday clinics were scheduled.

To encourage attendance for Saturday clinics, an open invitation was sent encouraging invitees to arrive at any convenient time between 9.00am – 5.00pm.

Creating an accessible clinic space

> "We have learnt that often if you don't address the social needs, you can't effectively address the physical health needs of an individual."
>
> *Katie Gutteridge, Practice Manager Bitterne Surgery and PCN Lead*

During and after the Covid pandemic, Bitterne Surgery worked closely with a social prescriber based in a local church. She supported those who were struggling with financial problems, food poverty and housing issues, signposting them to further help.

When considering how to set up the Saturday BP check clinics, Bitterne Surgery chose to use this community connection, and the existing trust built within the community.

Additional healthcare professionals (health care assistant and paramedic) were assigned to work alongside the social prescriber to take the blood pressure of those attending clinics, offer advice and further blood tests and subsequent treatment initiation, as and when required.

Adopting a whole person approach where both physical and social needs are considered and addressed helped the success of this initiative.

Making every contact count

"We ensure a professional able to prescribe medication is available so that blood pressure medication can be prescribed if required. People respond well to a seamless service that wraps itself around them."

Katie Gutteridge, Practice Manager Bitterne Surgery and PCN Lead

BP checks were not completed in isolation. If abnormal readings were identified, individuals were offered blood tests, an ECG to identify incidences of atrial fibrillation, or prescribed necessary medication during the same visit.

From the blood tests offered, 10 people were identified as having high cholesterol and were initiated on a statin medication.

Number of clinics run, attendance, and outcomes

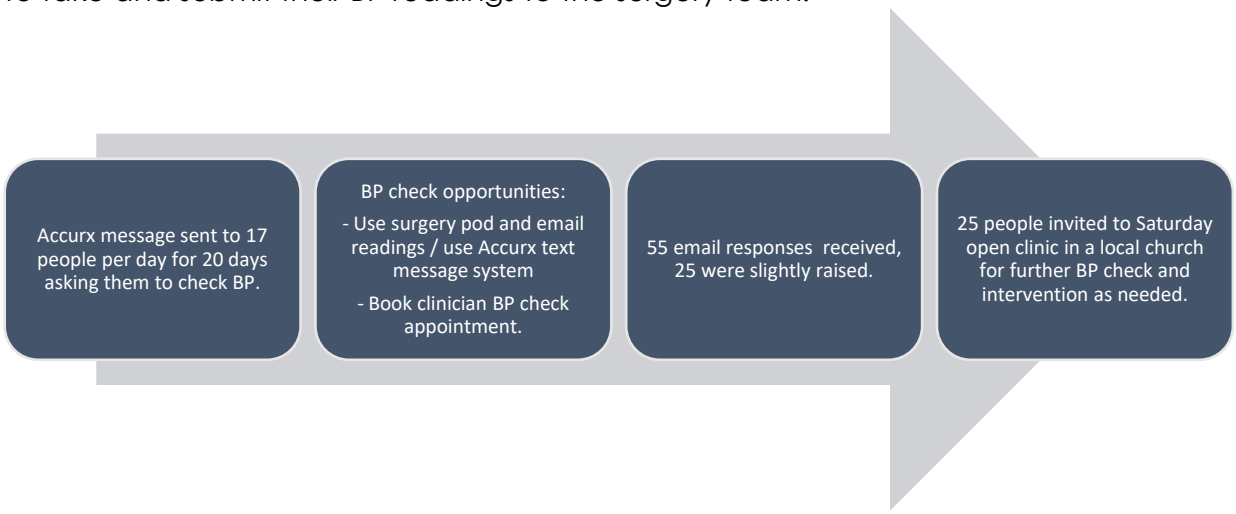
Table 1 below shows attendance and outcomes of five BP check clinics run by Bitterne Surgery between March and June 2024.

Clinic	Number of attendees	Number of high BP readings	Next steps	Atrial fibrillation identified
Sunday clinic 1	10	3	Interventions put in place, medication prescribed as needed and follow up appointments arranged.	0
Tuesday clinic 2	16	1	Interventions put in place, medication prescribed as needed and follow up appointments arranged.	0
Saturday clinic 3	25	9	Interventions put in place, medication prescribed as needed and follow up appointments arranged.	0
Tuesday clinic 4	5	1	Interventions put in place, medication prescribed as needed and follow up appointments arranged.	0
Saturday clinic 5 *(*details of additional initiative below)*	33	10	Interventions put in place, medication prescribed as needed and follow up appointments arranged.	4
Totals	**89**	**24**		**4**

Table 1

***Additional initiative prior to clinic 5:**
Using QOF data and the Ardens Portal for clinical decision support and data analytics, the practice identified 376 people (out of 1621 people ≤ 79 years old) who were due a blood pressure check within the next 12 months. Each had a target BP reading of 140/90 or under.

Infographic 2 shows the approach adopted to support this group of 376 individuals to take and submit their BP readings to the surgery team.



Infographic 2

Key stakeholders and their project roles

Key stakeholders included

- **Practice Patient Participation Group** – Supported development of approach and promotional material
- **Health Innovation Wessex** – Shared resources and delivery models, supported planning, developed case study, and evaluated project
- **Hampshire and Isle of Wight Integrated Care board** – Supported with funding, planning, project oversight and key milestones
- **Hampshire County Council** – Advice, guidance, and project oversight
- **Southampton City Council** – Advice, guidance, and project oversight

Experiences of those using the service

> "We run the clinics once a month, as a Saturday outreach clinic in a community location. We will continue to do that even after the three-month project is over. We found it has been positive for our entire population, for the people invited but also for us, the workforce. The outcomes reported from participants have been phenomenal."
>
> *Katie Gutteridge, Bitterne Surgery Practice Manager and PCN Lead*

Bitterne Surgery used the friends and family test to gather feedback from people who had attended BP check clinics. Some of the comments made are shared below, with permission:

"I felt at ease and loved the fact the GP surgery was at the church."

"I now feel comfortable going into surgery after meeting Angie."

"An amazing service and so friendly."

"Very efficient service and lovely staff."

"More GP surgeries should be like this one."

Participant stories

As a result of running additional Saturday clinics in the nearby St Christopher's Church in Thornhill, a social prescriber working closely with a paramedic and healthcare assistant reached an individual living with high blood pressure whom the surgery had not previously been able to engage with.

Previously excluded from healthcare provision due to an inability to afford the medication prescription cost, the team engaged with the individual in a non-medical location during the weekend, identified their high blood pressure, arranged repeat prescriptions without additional costs and signposted them to support addressing issues of living in poverty.

Another individual, reluctant to engage with the medical team in a GP surgery, had not had a diabetic check in three years. The healthcare assistant, employing health coaching techniques, ensured the person now has regular blood tests and health checks.

Summary of next steps

Based on the success of this approach both for those attending and for staff working in the clinics, Bitterne PCN has made a commitment to continue running a monthly Saturday clinic at St Christopher's Church.

Staff within the practice are supportive of the approach, with Saturday working rotas easy to fill. Staff report satisfaction in being able to deliver a preventative approach, in a location and at a time that includes those who are often under-served by health services. Staff have reported that they enjoy the Saturday work as the appointments are prebooked and the working environment offers an alternative to busy surgery weekdays.

Feedback from those attending clinics via the Friends and Family Test has continued to show high levels of satisfaction with the additional BP check clinics offered, alongside the practice showing evidence that QOF targets set for their service are consistently being met for CVD prevention.

Strategic alignment

This approach has been shown to positively impact the following areas:

- Reducing health inequalities
- Utilisation of digital technologies
- Public partnerships and community conversations
- Workforce welfare and design
- Real world impact
- CVD prevention continues to be a key priority for Hampshire and Isle of Wight Integrated Care Board and NHS England.

Bitterne PCN has committed to continue its approach of case finding people who would benefit from CVD prevention clinics, offering additional clinics in accessible locations and at a variety of times, enabling those often under-served by GP practices to access local CVD prevention services for the foreseeable future. There is a vision to spread the approach more widely across Bitterne PCN.

Thank you to Katie Gutteridge for providing the rich information on which this case study is based.

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